October 30, 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
Attention: Policy Analyst
P.O. Box 30670
Lansing, MI 48909-8170

Re: Midwifery – General Rules (ORR#2018-031 LR)

Dear Policy Analyst:

Thank you for the opportunity to provide input on the proposed Board of Midwifery rules, which will implement provisions of Public Act 417 of 2016. The signatories of this letter represent health care professionals and maternal and child health advocates who believe that patient safety and well-being must be our highest priority.

The American Academy of Pediatrics, American College of Nurse-Midwives, and American College of Obstetrics and Gynecology have all created thoughtful policy statements pertaining to planned home births. Each recognizes that there are women and their families who desire and will choose to have home births. They also recognize the need for informed choice and consent utilizing evidence-based protocols and counsel regarding standards of care. Included in that shared decision-making is the need to assess a variety of factors including the favorable prognosis for a healthy labor, birth, and postpartum experience, clinical practice guidelines, and the availability and timeliness of transport to a nearby hospital should that become necessary.

Our respective organizations urge the Michigan Department of Licensing and Regulatory Affairs (LARA) to take these standards into consideration when finalizing the Board of Midwifery rules. We believe that it is in the best interest of Michigan's women and children to support licensed midwives in the safe practice of caring for women during childbirth. Inclusive in this practice is respectful inter-professional collaboration, transparency, and ongoing communication.

On behalf of our respective members, we have several concerns with the proposed regulations as currently drafted. To ensure that the licensing of midwives will make the public safer and to ensure those seeking to be licensed as midwives are qualified to provide care, we would urge LARA to consider incorporating our joint recommendations prior to finalizing these rules. Our organizations believe they are consistent with the Legislature's directive to LARA in MCL 333.17117(c) to promulgate rules that "describe and regulate, limit, or prohibit the performance of acts, tasks, or functions by midwives" and, to "include rules that recognize and incorporate the requirements under section 17107 regarding the referral to and consultation with appropriate health professionals and ensure that those rules conform to national standards for the practice of midwifery…"

Attached is a grid and related attachment detailing these recommend changes, as well as a summary of those recommendations below.

Licensure

The goal of licensure and regulation is to assure appropriate minimum standards of education and preparation. Public Act 417 of 2016 gives the new midwifery board the authority to "promulgate rules to supplement the requirements for licensure."

Language is proposed to establish a benchmark for accrediting and credentialing program equivalency standards and recognition of successor organizations. Additional licensure criterion proposed to ensure that licensed midwives show proof of current CPR and neonatal resuscitation certifications, obstetric emergency skills training, high school graduation or GED, minimal prenatal, birth and postpartum experience, proof of current credential as Certified Professional Midwife, and proof of passing the required examination.

Regarding licensure by endorsement, we propose to require out-of-state licensed midwives to meet the same criteria as Michigan licensed midwives as directed by MCL 333.17119. This is critical since there is no assurance of equivalency among states or consistent criteria, especially when applicants may be reviewed for exceptions in education or certification in their licensing states.

The current proposal of a four-year licensure cycle is too long. Our organizations recommend that it be two-years, which is consistent with Board of Nursing requirements. As currently written, there is essentially no consequence to not renewing license over a period of nearly seven years given that the licensing cycle is proposed to be four years, and a midwife could allow his or her license to lapse for two years and 364 days. Additionally, we recommend some adjustments to the relicensure requirements.

Definitions

As currently written in the proposed rule, the definition of "appropriate health professional" would include every health professional licensed under the Public Health Code, even those with no obstetrical training or training in the practice of medicine or nursing such as dentists, veterinarians, physical therapists, social workers, etc. Our organizations propose the definition be scaled back to include physicians, physician's assistants, certified nurse practitioners, and certified nurse midwives with experience in the practice of obstetrics, pediatrics, or emergency medicine. These are the professionals that will be expected to consult with licensed midwives or take over the care of their patients when risk factors present. It is imperative that licensed midwives are collaborating with health professionals that have the appropriate training and experience.

The required hours of training under the definition of "appropriate pharmacology training" is proposed to be increased from eight hours to minimally 16. Eight hours is not sufficient training for the administration of medications to pregnant women and infants.

The definition of 'transfer" is modified to provide a stronger legal basis to assure transfer with the least risk of delay due to clear, previously agreed upon responsibility and adherence to national standards as required by MCL 333.17117(1)(e).

Based on suggested changes from our organizations later in the document, we are proposing to add the definition of "emergency medical services personnel". These front-line professionals will be assisting in emergency situations. To ensure a transparent transfer of care, they need to be recognized in the rules.

Informed Consent

The current proposed rules only require informed disclosure of certain information where the statute (MCL 333.17109) clearly requires informed consent at inception and continuation of care. We recommend that the statute be followed, and written informed consent be required. We are also suggesting that additional information be provided during the process to ensure transparency to the patients regarding expectations around consultation, transfer of care, the care team, and any collaborative relationships.

Consultation, Referral and Transfer of Care

We collectively recommend that the issues of consultation/referral and transfer of care/transport to hospital be addressed in two separate rules to ensure clarity. Therefore, Attachment A reflects the suggested restructure of current proposed rule 333. The rationale for items under our proposed "required transfer of care" is that these conditions move the pregnancy from a low or normal risk pregnancy into higher risk categories which are more likely to result in complications and the need for medical intervention by an appropriate health professional.

Additionally, language changes are proposed regarding action to be taken by the licensed midwife when the mother and/or infant require transportation to a hospital to ensure the patients' safety and a smooth care transition. In emergency situations, at a minimum, we would request that a licensed midwife be required to remain with the patient and continue to provide care until an appropriate health care provider has assumed care of the patient. Additionally, consistent with standards of practice, the licensed midwife should be expected to communicate with appropriate health professionals on the mother's and/or infant's condition and, when possible, present their medical records.

Finally, the addition of a new rule is proposed to establish minimum criteria and expected protocols for the transfer of care plan.

Administration of Medication

In the interest of patient safety, this rule should be amended to limit those who may issue the standing prescriptions to a physician or certified nurse midwife with current experience in obstetrics. If any additional medications need to be added to the list, they should be added through the rules promulgation process to ensure the opportunity for adequate public review and input. Finally, there are some medications that are given to newborns within hours of birth. If the licensed midwife is not qualified to administer that medication or the family refuses, the licensed midwife should minimally make the recommendation that the family see an appropriate health professional to obtain that medication.

Continuing Education

We are proposing a slight modification to make the continuing education more consistent to that of nurses by requiring at least 25 credits every two years. Additionally, the recommendation is that at least 20 hours come from activities to maintain their credential, one hour in pain and symptom, two hours in cultural awareness and one hour in pharmacology.

As noted previously, our goal is to increase the likelihood of safe deliveries and post-partum care for mothers and infants. These rules must signify a level of regulation and safe practice that all stakeholders, especially the public, can trust. We believe our suggestions assist in achieving that outcome.

Thank you for your consideration of our recommended changes. Significant effort has been made in the last few years within state government and in communities, in partnership with the undersigned to lower Michigan's rate of infant and maternal mortality, we need midwifery rules that reflect this priority. If you have any questions or need any additional information, please do not hesitate to reach out to any or all of our organizations.

Respectfully submitted,

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Attachments (3)
List of additional individuals and organizations in support of this joint statement
Grid of recommended changes and Attachment A

ATTACHMENT A

R 338.17134 **Required** Consultation and Referral.
Rule 134. (1) A licensed midwife shall consult with or refer to an appropriate health professional, document the consultation or referral and any recommendations of the consultation, if the patient is determined to have any of the following conditions during the current pregnancy:

(a) Antepartum:

(i) Gestational hypertension.

(ii) Blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure.

(iii) Persistent, severe headaches, epigastric pain, or visual disturbances.

(iv) Persistent symptoms of urinary tract infection.

(v) Significant vaginal bleeding before the onset of labor not associated with uncomplicated spontaneous abortion.

(vi) Noted abnormal decrease in or cessation of fetal movement.

(vii) Hemoglobin level less than 9 and resistant to supplemental therapy.

(viii) A temperature of 100.4 degrees Fahrenheit or 38.0 degrees Celsius or greater for more than 24 hours.

(ix) Isoimmunization, Rh-negative sensitization, or any other positive antibody titer, which would have a detrimental effect on the mother or fetus.

(x) Abnormally elevated blood glucose levels unresponsive to dietary management.

(xi) Symptoms of severe malnutrition, severe persistent dehydration, or protracted weight loss.

(xii) Symptoms of deep vein thrombosis.

(xiii) Documented placenta overlying the site of a previous uterine scar.

(xiv) Fetus with diagnosed congenital abnormalities that will require immediate medical intervention at birth.

(xv) Pelvic or uterine abnormalities affecting normal vaginal births, including tumors and malformations.

(xvi) Marked abnormal fetal heart tones.

(xvii) Abnormal non-stress test or abnormal biophysical profile.

(xviii) Suspected intrauterine growth restriction.

(xix) Suspected perinatal mood disorder or uncontrolled current serious psychiatric illness.

(xx) Suspected active alcohol use disorder.

(xxi) Suspected active substance use disorder.

(xxii) Sexually transmitted infection.

(xxiii) Symptoms of ectopic pregnancy

(xxiv) Symptoms or evidence of hydatidiform mole.

(xxv) Thrombocytopenia with a count less than 100,000 platelets per microliter.

(xxvi) Vaginal infection unresponsive to treatment.

(xxvii) Symptoms of hepatitis.

(xxviii) Significant hematological disorders or coagulopathies, or pulmonary embolism.

(xxix) Gestation beyond 42 weeks.

(xxx) Hyperreflexia.

(xxxi) New onset pitting edema.

(xxxii) Clonus.

(xxxiii) Rheumatoid arthritis.

(xxxiv) Chronic pulmonary disease.

(xxxv) Abnormal liver or metabolic panel.
(xxvi) Abnormal PAP test results.
(xxxvii) Chronic pulmonary disease.
(xxxviii) Gestation beyond 42 weeks.
(xxxvii) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment.

(b) Intrapartum:
(i) Blood pressure exceeding 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure.
(ii) Persistent, severe headaches, epigastric pain or visual disturbances.
(iii) Temperature over 100.4 degrees Fahrenheit or 38.0 degrees Celsius in absence of environmental factors.
(iv) Signs or symptoms of maternal infection.
(v) Confirmed ruptured membranes without onset of labor after **24** hours.
(vi) Excessive vomiting, dehydration, acidosis, or exhaustion unresponsive to treatment.
(vii) Uncontrolled current serious psychiatric illness.
(viii) **Fetal heart rate anomalies.**
(viii) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment.

(c) Postpartum:
(i) Failure to void bladder within 6 hours of birth.
(ii) Temperature of 101.0 degrees Fahrenheit or 39 degrees Celsius for more than 12 hours.
(iii) Signs or symptoms of uterine sepsis.
(iv) Symptoms of deep vein thrombosis.
(v) Suspected perinatal mood disorder or uncontrolled current serious psychiatric illness.
(vi) Suspected active alcohol use disorder.
(vii) Suspected active substance use disorder.

(2) **A licensed midwife shall consult with or refer to an appropriate health professional, and document the consultation or referral, if the newborn demonstrates any of the following conditions**:

a. **Weight less than 2500 grams or 5 pounds, 8 ounces**.
b. Abnormal metabolic infant screening.
c. Failed hearing screening.
d. Jaundice occurring outside of normal range.
e. Failure to urinate within 24 hours of birth.
f. Failure to pass meconium within 48 hours of birth.
g. Medically significant nonlethal congenital anomalies.
h. Suspected birth injury.
i. Signs of clinically significant dehydration.
j. Signs and symptoms of neonatal abstinence syndrome.
k. Lethargy.
l. Irritability.
m. Abnormal crying.
n. **Poor feeding.**
o. Any other abnormal infant behavior or appearance that could adversely affect the health of the infant, as assessed by a licensed midwife exercising reasonable skill and judgment.

(3) When a referral to an appropriate health professional is made, after referral the licensed midwife may, if possible, remain in communication with the appropriate health professional until resolution of the concern.

(4) If the patient elects not to accept a referral or an appropriate health professional's advice, the licensed midwife shall:
(a) Obtain full informed consent from the patient and document the refusal in writing;
(b) Discuss with the patient what the continuing role of the licensed midwife will and whether the licensed midwife will continue or discontinue care of the patient.
(c) If birth is imminent, call 9-1-1 and remain with the patient until emergency services personnel arrive, transfer care, and give a verbal report of the care provided to the emergency medical services providers.

(5) Neither consultation nor referral precludes the possibility of continued care by a licensed midwife or the possibility of an out-of-hospital birth. The licensed midwife may maintain care of the patient to the greatest degree possible.

R 338.17135 **Required transfer of care to an appropriate health professional**.
Rule 135. (1) **A licensed midwife shall arrange for the orderly transfer of care of a patient to an appropriate health professional if any of the following disorders or situations exit**:
(a) Diabetes mellitus, including uncontrolled gestational diabetes;
(b) Hyperthyroidism treated with medication;
(c) Uncontrolled hypothyroidism;
(d) Epilepsy with seizures or antiepileptic drug use during the previous 12 months;
(e) Coagulation disorders;
(f) Heart disease in which there are arrhythmias or murmurs except when, after evaluation, it is the opinion of a physician or certified nurse mid-wife or certified nurse practitioner that midwifery care may proceed;
(g) Hypertension, including pregnancy-induced hypertension (PHI);
(h) Renal disease;
(i) Rh Sensitization with positive antibody titer;
(j) Previous uterine surgery, including a cesarean section or myomectomy;
(k) Indications that the fetus has died in utero;
(i) Premature labor (gestation less than 37 weeks);
(m) Multiple gestation;
(n) Noncephalic presentation at or after 38 weeks;
(o) Placenta previa or abruption;
(p) Preeclampsia;
(q) Severe anemia, defined as hemoglobin less than 9g/dL;
(r) Addison's disease;
(s) Cushing's disease;
(t) Systemic lupus erythematosus;
(u) Antiphospholipid syndrome;
(v) Scleroderma;
(w) Cancer;
(x) Periarteritis nodosa;
(y) Marfan's syndrome;
(z) AIDS/HIV;

(aa) Hepatitis A through G and non-A through G;
(bb) Acute toxoplasmosis infection, if the patient is symptomatic;
(cc) Acute Rubella infection during pregnancy;
(dd) Acute cytomegalovirus infection, if the patient is symptomatic;
(ee) Acute Parvovirus infection, if the patient is symptomatic;
(ff) Alcohol abuse, substance abuse, or prescription abuse during pregnancy;
(gg) Continued daily tobacco use into the second trimester;
(hh) Thrombosis;
(ii) Inflammatory bowel disease that is not in remission;
(jj) Primary herpes simplex virus, genital infection during pregnancy, or any active genital lesions at the time of delivery;
(kk) Significant fetal congenital anomaly;
(ll) Ectopic pregnancy;
(mm) Rupture of membranes prior to the 36.6 weeks of gestation without active labor.
(nn) Marked or severe hydramnios or oligohydramnios.
(oo) Other diseases and disorders, as determined by the Department;
(pp) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment; or
(qq) The patient requests transfer.

(2) When a transfer of care to an appropriate health professional is made, the licensed midwife may, if possible, remain in communication with the appropriate health professional until resolution of the concern.

(3) A licensed midwife shall arrange immediate transfer of care and transport to a hospital for the following conditions:

(a) Mother:

(i) Seizures.
(ii) Unconsciousness.
(iii) Respiratory distress or arrest.
(iv) Maternal shock unresponsive to treatment.
(v) Symptoms of maternal stroke.
(vi) Symptoms of suspected psychosis.
(vii) Symptomatic cardiac arrhythmias or chest pain.
(viii) Prolapsed umbilical cord.
(ix) Symptoms of uterine rupture.
(x) Symptoms of placental abruption.
(xi) Symptoms of preeclampsia or eclampsia.
(xii) Severe abdominal pain inconsistent with normal labor.
(xiii) Symptoms of pulmonary or amniotic fluid embolism.
(xiv) Symptoms of chorioamnionitis that include the presence of a fever greater than 100.4 degrees Fahrenheit or 38.0 degrees Celsius and 2 of the following 3 signs: uterine tenderness, maternal or fetal tachycardia, or foul/purulent amniotic fluid.
(xv) Unresolved fetal malpresentation not compatible with spontaneous vaginal delivery.
(xvi) Hemorrhage non-responsive to therapy.
(xvii) Uterine inversion.
(xviii) Persistent uterine atony.
(xix) Symptoms of anaphylaxis.

(xx) Failure to deliver placenta within 2 hours in the third stage.
(xxi) Persistent abnormal vital signs.
(xxii) Significant abnormal bleeding prior to delivery, with or without abdominal pain.
(xxiii) Fetal distress evidenced by abnormal fetal heart tones when birth is not imminent.
(viii) Lacerations requiring repair beyond the scope of practice of the licensed midwife.
(ix) Any other condition or symptom that could threaten the health of the mother as assessed by a licensed midwife exercising reasonable skill and judgment.

(b) Infant:
(i) Persistent cardiac irregularities.
(ii) Persistent central cyanosis, pallor, or abnormal perfusion.
(iii) Persistent lethargy or poor muscle tone.
(iv) Seizures.
(v) Apgar score of 6 or less at 5 minutes without significant improvement by 10 minutes.
(vi) Non-transient respiratory distress.
(vii) Significant signs or symptoms of infection.
(viii) Evidence of unresolved hypoglycemia.
(ix) Abnormal, bulging, or depressed fontanel.
(x) Persistent breathing at a rate of more than 60 breaths per minute.
(xi) Temperature persistently over 99.0 degrees Fahrenheit or less than 97.6 degrees Fahrenheit.
(xii) Abnormal crying.
(xiii) Significant evidence of prematurity.
(xiv) Clinically significant abnormalities in vital signs, muscle tone, or behavior.
(xv) Failed critical congenital heart defect screening.
(xvi) Persistent inability to suck.
(xvii) Clinically significant abdominal distension.
(xviii) Clinically significant projectile vomiting.

(4) As required under Rule 3 of this Section, the licensed midwife shall initiate immediate transport according to the licensed midwife's emergency care plan; provide necessary emergency stabilization until emergency medical services arrive or transfer to emergency medical services personnel or an appropriate health professional is completed; provide pertinent information to emergency medical services personnel or an appropriate health professional; and is encouraged to fill out a patient transfer form provided by the department.

(5) Transport via private vehicle is an acceptable method of transport if it is the most expedient method for accessing medical services **and the licensed midwife, an appropriate health care professional or emergency medical services personnel accompanies the patient**.

(6) A licensed midwife shall continue to provide care to a patient with any of the complications or conditions set forth in this rule under any of the following circumstances **until the licensed midwife is able to complete the transfer care to emergency medical services personnel or an appropriate health professional as provided in subrule (4):**
a. If no appropriate health professional or other equivalent medical services are available.
b. If delivery occurs during transport.
c. If the patient refuses to be transported to the hospital.
d. If the transfer or transport entails futility, or extraordinary and unnecessary human suffering.

(7) The licensed midwife may remain in consultation with the appropriate health professional after a transfer is made.

(8) If authorized by the patient, a licensed midwife may be able to be present during the labor and childbirth, and care may return to the midwife upon discharge.

PROPOSED MIDWIFERY RULE	PROPOSED REVISIONS TO BOARD OF MIDWIFERY RULES	COMMENTS/RATIONALE
R338.17113 – Licensed Midwifery Accrediting Organizations	Amend (1) and (2) to read as follows: (1) The board approves the midwifery accreditation council (MEAC), **or its successor entity,** as an accrediting organization. (2) A petition may be filed with the board for approval of a midwifery accrediting organization. **The board may approve a petition only if the standards and evaluative criteria of the organization are determined to be equivalent to the standards of the MEAC.**	Clinical standards are not subjective and should not be decided upon a case-by-case basis. There needs to be a mechanism for future organizations, but they need to be equivalent to meet the standards established in the original act.
R338.17115 – Licensed Midwifery Accrediting Organizations	Amend to read as follows: Rule 115. The board may approve a licensed midwifery credentialing program **only** if **its standards and evaluative criteria** are equivalent to the credential of certified professional midwife (CPM) from the North American registry of midwives (NARM), meets the criteria of section 16148 of the code, MCL 333.16148, and is accredited by the national commission for certifying agencies (NCCA) **or an accrediting organization approved pursuant to Rule 113**.	As noted above, any mechanism intended to recognize future organizations must ensure equivalency to meet the standards established in the original act.
R 338.17121 - Licensure	Amend (1) to require all of the following be submitted with the completed application and requisite fee: • Proof of current CPR and neonatal resuscitation certification from courses that include a hands-on skill component • Proof of competition of obstetric emergency skills training • A photocopy of a high school diploma or a GED certificate • Documentation verifying the applicant has at least minimal practice experience • Proof of current credential as CPM or another credential as permitted by MCL 333.17115 • Proof of a passing score on the Board approved examination Regarding (2) and (3), establish a process and criteria for determining "equivalency."	Additional licensure requirements are included to ensure completion of basic competencies to ensure the safety of both the mother and child. Variation in how equivalence is determined deters from the ability to assure public health and safety, as well as consistent expectations related to the practice of a midwife. It is critical that the criteria remain equivalent to meet the standards in the act for the protection of the public. MEAC accredited programs should be the bare minimum preparation for practice. This is critical to the safety of our families.

R 338.17123 - Licensure by Endorsement	Amend Rule 123 to read as follows: Rule 123. To be eligible for licensure by endorsement, an applicant must meet the requirements of sections 16174 and 17119 of the code, MCL 333.16174 and MCL 333.17119, and must submit all of the following: (1) A completed application, on a form provided by the department; (2) The requisite fee; (3) Proof of current CPR and neonatal resuscitation certification from courses that include a hands-on skills component. Approved CPR courses include the American Heart Association and the Red Cross. Neonatal resuscitation courses must be approved by the American Academy of Pediatrics, the Canadian Paediatric Society, or pre-approved by the Board; (4) Proof of completion of obstetric emergency skills training such as Birth Emergency Skills Training (BEST) or an Advanced Life Saving in Obstetrics (ALSO) course; (5) A photocopy of a high school diploma or a GED certificate; (6) Documentation verifying the applicant has at least minimal practical experience in the provision of prenatal examinations and supervised participation in births, newborn examinations, and postpartum examinations; (7) Proof of current credential as CPM or other credential as permitted by section 17115 of the code, MCL 333.17115; and (8) Proof of passing the national examination required of licensed midwives in this state.	There is no assurance of equivalency among states, especially when applicants may be reviewed for exceptions in education or certification in states without the assurance that equivalency was determined by consistent criteria. Public health and safety may be jeopardized by inconsistent application of equivalency criteria. Consistent with the recommendation for modification to Rule 121, the proposed language for Rule 123 includes additional licensure requirements to ensure completion of basic competencies to ensure the safety of both the mother and child.
R 338.17125 – Relicensure	Include inducements to maintain current licensure. Amend (1)(e) in the table to require completion of the examination if the license has lapsed more than 3 years but less than 7 years. Amend (2) to read as follows: (2) For a midwife who has let his or her Michigan license lapse, but who holds **an equivalent**, current, and valid licensed midwife license in another state:	There is essentially no consequence to not renewing license over a period of nearly 7 years given that the licensing cycle is proposed to be 4 years, and a midwife could allow his or her license to lapse for 2 years and 364 days. In this scenario, the licensee would only need to get fingerprinted, and have 30 hours of continuing education sometime in the last three years prior to applying for relicensure. As a result, a licensee could feasibly go nearly 11 years after initial

		licensure prior to paying the fee and relicensing, with only 30 hours of continuing education. CPM licensure criteria varies state to state; any licensure in a different state must be equivalent to MI criteria if it is to be considered a basis for licensure in Michigan.
R338.17131 – Definitions	Amend the following definitions to read as follows: "Appropriate health professional" means any physician, physician's assistant, nurse practitioner or certified nurse-midwife with experience in the active practice of obstetrics, pediatrics, or emergency medicine and licensed under article 15 of the public health code. "Appropriate pharmacology training" means a minimum of 16 hours of training related to pharmacology applicable to midwifery practice, approved by MEAC or the board. "Transfer" means to convey the responsibility for the care of a patient to another appropriate health professional in accordance with nationally recognized guidelines on safe transfer as indicated in section 17117(1)(e), MCL 333.17117(1)(e). Add the following definition: "Emergency medical services personnel" means an individual licensed as an "emergency medical services personnel" under article 17 of the public health code.	The definition of "appropriate health professional" as proposed in the current draft rule would include every health professional licensed under the Public Health Code, even those with no obstetrical training or training in the practice of medicine or nursing such as dentists, veterinarians, physical therapists, social workers, etc. This definition needs to be narrowed to include physicians, physician's assistants and certified nurse midwives and NPs with experience in the active practice of obstetrics, pediatrics, or emergency medicine as these are the professionals that will be expected to consult with licensed midwives or take over the care of their patients when risk factors present. It is imperative that licensed midwives are collaborating with health professionals that have the appropriate training and experience. The eight hours of training proposed in the definition of "appropriate pharmacology training" in the current draft is not is not sufficient training for the administration of medications to pregnant women and infants. The drugs and medications listed have the potential

		for severe side effects, highly sensitive responses to reactions, dosages, etc. Neonates and infants have a very small margin of error for overdosing of medication. They are especially vulnerable to severe damage from reactions, dosing. The proposed definition of 'transfer" is intended to provide a stronger legal basis to assure transfer with the least risk of delay due to clear prior agreed upon responsibility. Makes a clear connection and easy reference for the provider. The definition of "emergency medical services personnel" is proposed to be added since forthcoming recommendations include references to emergency medical services personnel.
R338.17132 – Informed Disclosure and Consent	Require the licensee to provide the patient with an informed disclosure and consent process at the inception of care. Require informed consent to be provided in writing. Include the following in the list of items to be disclosed: • Conditions under which consultation, transfer of care, or transport of the patient must be initiated. • Information regarding the midwife's care team. • Whether the licensed midwife has entered into a collaborative relationship with an appropriate health professional and, if so, the names and contact information of those health professionals. Strike 338.17132(4).	This is the standard of care for freestanding birth centers, including their plans for transport, their limits of care and the options for a patient if the patient falls outside of their scope. These are provided to patients in order to facilitate communication and make clear the limits of the location in which they are birthing in addition to the providers scope and the subsequent parental responsibilities. In the case of an emergency, the woman and her family deserve to be communicated with, informed of their options and offered an explanation of the issues.

338.17133 – Additional informed consent requirements	Amend (1)(b) to read as follows: (b) Fetus in a breech presentation **at the time of discovery if after 34 weeks**. Amend (2) to read as follows: (2) A licensed midwife shall disclose to the patient **relevant practice guidelines, as well as his or her education, training and experience pertaining to** the management of the pregnancies listed in subrule (1) of this rule, which must include the licensed midwife's level of experience, type of special training, care philosophy, and outcome history relative to such circumstances. Amend (4) to read as follows: (4) The licensed midwife **shall disclose his or her obligation to practice within the rules and regulations of the state and his or her level of education, training and experience**. Amend (5) to read as follows: (5) The licensed midwife shall provide the patient with an informed choice document, specific to the patient's situation, which includes the following: (a) **Evidence-based information regarding** the **potential increased risks and benefits associated with the** circumstances listed in subrule (1) of this rule. (b) **Evidence-based information regarding** the **potential increased risks and benefits associated with the** birth outside a hospital setting **when** the circumstances listed in subrule (1) of this rule **are present**. (c) **Evidence-based information regarding medical care** options associated with the circumstances listed in subrule (1) of this rule **together with referral to an appropriate health professional for further discussion** about medical care options, including the risks of cesarean section, both in the current pregnancy and any future pregnancies.	Breech prior to this gestational age is normal and does not require any different care or consult/transfer. References to "personal practice guidelines" are deleted. Guidelines are professional standards of care not personal. Referring to "personal guidelines" implies the capacity for variation which is undesirable in assuring public health and safety. The patient needs to understand the scope of practice attributable to the licensed midwife should the patient's or her baby's condition change to the extent that the licensed midwife would be needing to transfer care. When providing information to assist with shared decision-making and informed consent, it must be balanced and based on evidence not personal philosophy. Medical issues that fall outside of their scope of practice should be addressed by appropriate health professionals.
338.17134 - Consultation and Referral Rule	Retitle to read: "**Required** Consultation and Referral" Suggest that R 338.17134 and R 338.17135 be restructured to better clarify the situations in which consultations, referrals and transfers or care are required and the process for doing so; add a new (2) to separate out conditions related to newborns that may require	The listed symptoms and conditions require clinical judgement and diagnosis and management that are outside the scope of practice of the licensed midwife.

	consultation or referral; add a (4) to provide further specificity as to action to be taken if the patient refuses referral or advice – See Attachment A. Amend (1) to read as follows: "(1) A licensed midwife shall consult with or refer a patient to an appropriate health professional, and document the consultation or referral and any recommendations of the consultation, if the patient is determined to have any of the following conditions during the current pregnancy:" Amend blood pressure to 140/90 and include an additional parameter of blood pressure to be increased by 30mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure. Under "Antepartum": Add - "hyperreflexia", "new onset pitting edema", "clonus", "rheumatoid arthritis", and "chronic pulmonary disease". Under "Intrapartum": Amend – "Confirmed ruptured membranes without onset of labor after **24** hours." Add – "Fetal heart rate anomalies."	The proposed Rules, as currently written, are unclear as to whether and when a licensed midwife is required to seek a consultation or make a referral. The proposed modification adds specificity to the actions to be taken to avoid delays in care to that may be detrimental to the health of the mother and/or infant. Need to ensure that licensed midwives are following standard guidelines for intermittent auscultation of the fetus.
R 338.17135 - Emergent Transfer of Care	See above suggestion to restructure R 338.17134 and R 338.17135 – See Attachment A. Amend title to read: "Required transfer of care". .	The rationale for items under the proposed "required transfer of care" is that these conditions move the pregnancy from a low or normal risk pregnancy into higher risk categories which are more likely to result in complications and the need for medical intervention by an appropriate health professional. Language is proposed to require action to be taken by the licensed midwife when the patient needs to be transported to a hospital to ensure the patient's safety and the expectation that the midwife ensures a smooth transition of care.

R 338.17136 – Prohibited Conduct	Add the following to the list of prohibitions under Rule 136: (e)(xi) Previous uterine surgery. (f)Pharmacological induction or augmentation of labor or artificial rupture of membranes prior to onset of labor. Previous (g)Cesarean section (VBAC) or myomectomy.	To ensure the safety of the mother and fetus, it needs to be clear that these items are absolute contraindications.
Proposed: R 338.17135A – Transfer of Care Plan	Add a new Rule, R 338.17135A, to identify what is required of a transfer of care plan. A licensed midwife shall create a transfer of care plan that minimally includes the following: (a) Conditions under which the midwife will transfer of care to an appropriate health professional. (b) Identification of hospitals to which the patient may be transported. (c) Protocols for contacting 9-1-1 or other emergency medical services personnel. (d) Protocols for implementing emergency medical procedures including but not limited to cardiopulmonary resuscitation and administration of oxygen. (e) Protocols for accompanying the patient to a hospital if transport in a private vehicle is the most expedient method for accessing medical services. (f) Protocols for notifying the emergency room or labor and delivery unit of the designated hospital of the imminent transport and providing the staff at the receiving facility with the patient's complete medical record and verbal report on the patient's status. (g) Protocols for care and appropriate attendant for infant in need of transport while maintaining appropriate care of maternal patient.	Minimum criteria and expected protocols for the transfer of care plan should be identified in rules. According to the Best Practice Guidelines: Transfer from Planned Home Birth to Hospital, "Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital." It is standard of care for a homebirth to have a second provider for the baby, but protocols should be developed to assure that there is an appropriate level of care for both patients if one needs transport for additional care, especially in emergent situations.
R 338.17136- Prohibited Conduct	Amend (d) by striking "frenulum revisions".	This is not standard within NARM skill set or within NACPM. It requires additional education not addressed in the licensing criteria.

R 338.17137 – Administration of Prescription Drugs or Medications	Amend (1) to read as follows: (1) A licensed midwife who has appropriate pharmacology training and holds a standing prescription from **a physician or certified nurse-midwife with experience in the active practice of obstetrics**, may, but is not required to, administer the following prescription drugs and medications." Require that any other drugs or medications authorized by the board be added by Rule. Divide Table 1, which is referenced in (2), into two segments - - administration to mother and administration to infant. Add a new (3) to read as follows: (3) A licensed midwife who does not administer a prescription drug or medication to a newborn pursuant to the American Academy of Pediatrics standards as described in *Guidelines for Perinatal Care* shall inform and recommend that the patient receive such drug or medication from an appropriate health professional as soon as possible.	In the interest of patient safety, the physician or certified nurse midwife who issues a standing order needs to have current experience and training in obstetrics. If any additional medications need to be added to the list, they should be added through the rules promulgation process to ensure the opportunity for adequate public review and input. It is important that the medical community be able to publicly comment on the addition of medications to ensure that such additions are appropriate and take into consideration patient safety. Subsection (2) directs licensed midwives to utilize Table 1 for "indications, dose, route of administration, duration of treatment, and contraindications" when administering medications. To reduce confusion and potential for errors with medications which are used for both patients in critically different dosages.
R338.17141 – License renewals; Requirements; Applicability	Require a licensure period of 2 years. Require 25 hours of continuing education prior to renewal that are approved by the board pursuant to those rules during the 2 years preceding an application for renewal and that is inclusive of all of the following: • At least 20 hours - obtaining and maintaining, the credential of CPM from NARM, or an equivalent credential approved. • One hour - pain and symptom management pursuant to section 16204(2) of the code, MCL 333.16204(2). • Two hours - cultural awareness. • One hour - pharmacology applicable to midwifery practice.	Compared with other health professional licensees, 4 years is too lengthy for a licensure period. The purpose is to protect the public. This continuing education proposal is more consistent to that of nurses by requiring at least 25 credits every two years.

Table 1	Identify the source for this document. As proposed under R 338.17137, divide Table 1, which is referenced in (2), into two segments - - administration to mother and administration to infant. Identify party responsible for ensuring the currency of the Table, as well as timeline for review and updating.	The source for this document is not identified. Only sources that are evidence based should be utilized. Additionally, it is not clear who is responsible for maintaining the document's currency in relation to evolving national standards.
R 338.17141	Establish a 2-year license cycle. Require a minimum of 25 credit hours of continuing education every licensure cycle. Of the 25 hours, 20 be met by obtaining and maintaining, the credential of CPM from NARM, or an equivalent credential approved by the board by Rule; 1 hour must be related to pain and symptom management pursuant to section 16204(2) of the code, MCL 333.16204(2); Two hours on cultural awareness; and, one hour of continuing education in pharmacology applicable to midwifery practice.	Make the continuing education more consistent to that of nurses by requiring at least 25 credits every two years.

Additional Individuals/Organizations in Support of Joint Letter from American Nurses Association Michigan, Michigan Affiliate of the American College of Nurse Midwives, Michigan Council for Maternal and Child Health, Michigan Council of Nurse Practitioners, Michigan Health & Hospital Association, Michigan Section-ACOG and Michigan State Medical Society

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